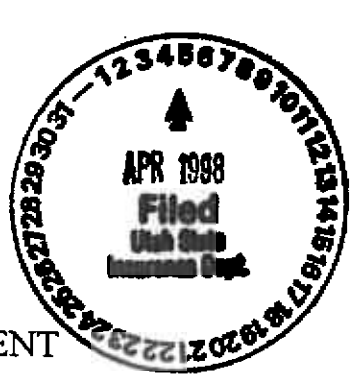


STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF MARKET CONDUCT EXAMINATION

of

PACIFICARE OF UTAH, INC.

35 West Broadway
Salt Lake City, Utah 84101

NAIC Company Code Number: 95407

and its sister company

PACIFICARE HEALTH OPTION, INC.

NAIC Company Code Number: 95406

as of

June 30, 1997

TABLE OF CONTENTS

March 5, 1998

The Honorable Merwin U. Stewart
Insurance Commissioner
Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

In accordance with your instructions, an examination has been made of the market conduct practices of

PACIFICARE OF UTAH, INC.
Salt Lake City, Utah

a domestic health maintenance organization, hereinafter referred to as the Company, as of June 30, 1997. The examination also included its sister company, PacifiCare Health Option, Inc., also a domestic health maintenance organization, hereinafter referred to as Health Option.

The report of such examination is herein respectfully submitted.

FOREWORD

The market conduct examination report is, in general, a report by exception. Reference to Company practices, procedures, or files subject to review may be omitted if no improprieties are encountered by the examiners.

SCOPE OF EXAMINATION

This examination was conducted by examiners representing the Utah Insurance Department in accordance with the Model Market Conduct Examination Handbook of the National Association of Insurance Commissioners and Utah Code Annotated (U.C.A.) 31A-2, Administrations of the Insurance Laws. The period covered by the examination was January 1, 1994 to June 30, 1997. Where considered appropriate, transactions of the Company prior and subsequent to the examination period were reviewed.

The purpose of the examination was to determine both the Company and Health Option's compliance with the Utah Insurance Code (U.C.A. 31A), and Rules promulgated by the Utah Insurance Department as contained in the Utah Administrative Code (U.A.C.) applicable to U.C.A. 31A, as pertains to the entities' market conduct affairs, and to determine if Company operations were consistent with public interest.

COMPANY PROFILE

History

The Company is an outgrowth of FHP, Inc., formerly Family Health Program, Inc., originally incorporated in the State of California in July 1961. FHP, Inc. was acquired by FHP International Corporation during November 1985. The Company was organized by FHP, Inc. and issued a certificate of authority by the Utah Insurance Department as a domestic health maintenance organization (HMO) during June 1987. Health Option was organized by FHP, Inc. as a non-federally qualified HMO and issued a certificate of authority by the Utah Insurance Department during September 1987.

During 1996, the Company was restructured from a fundamentally staff model HMO to a contract model HMO. Those medical facilities not disposed of were leased to Talbert Medical Management Corporation. Its staff medical service providers were employed by Talbert companies and the Company contracted with Talbert for the services of the providers as the core of its health care delivery system.

The Company's name was changed from FHP of Utah, In. following the merger of FHP International Corporation and PacifiCare Health Systems, Inc. during 1997. Health Option's name was changed from Employees Choice Health Option following the merger.

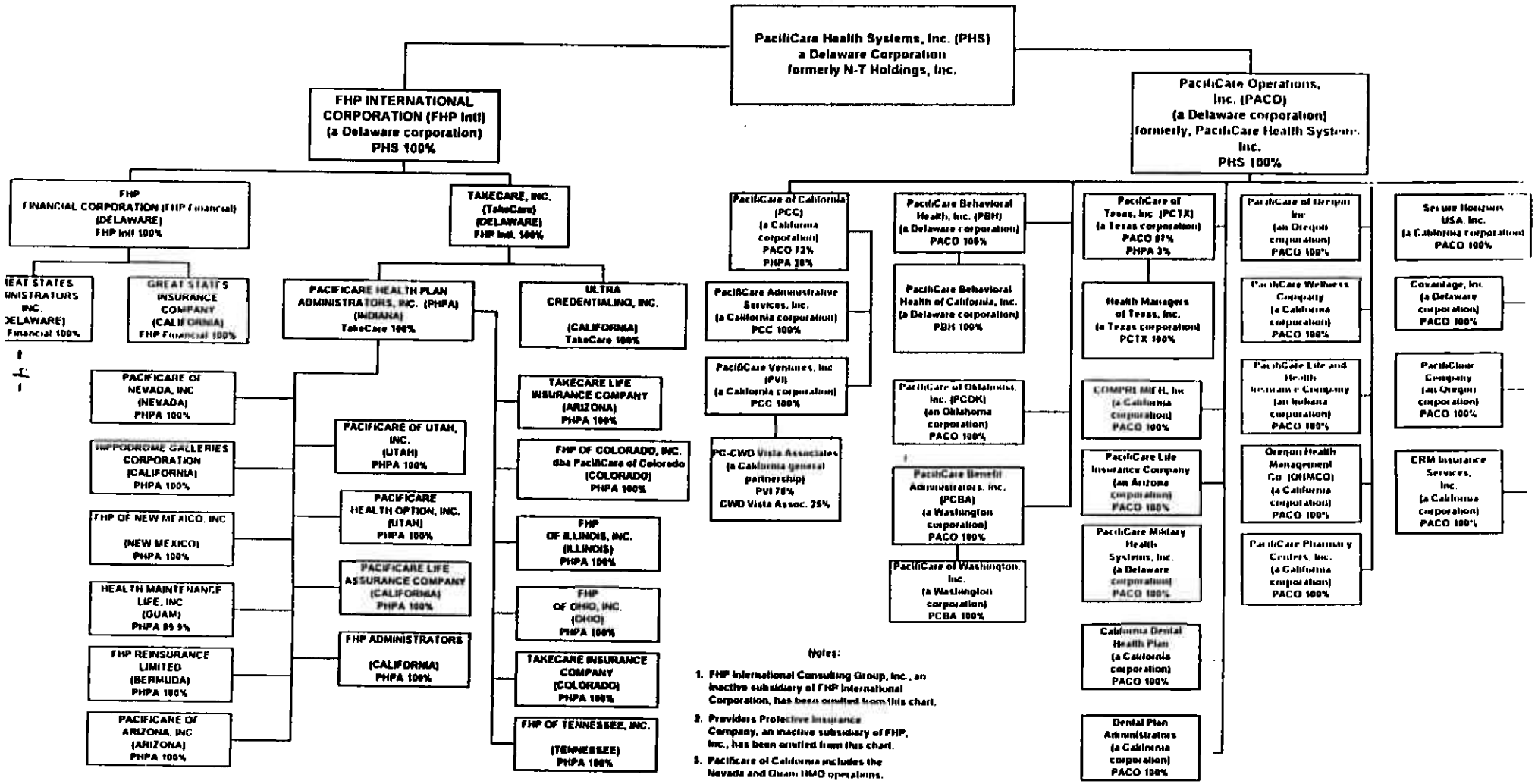
In November 1997, PacifiCare Health Systems, Inc. issued a press release announcing its intent to sell its Utah operations and exit the Utah market.

As of the examination date, the Company was approved by the Health Care Financing Administration as an independent federally qualified HMO. It was also approved to offer medicare risk plans in Utah.

Affiliated Companies

The chart on the following page, which was provided by the Company, depicts the ownership of the Company, Health Option, and their affiliates as of August 1, 1997. As shown in the chart, the Company and Health Option are 100% wholly owned subsidiaries of PacifiCare Health Plan Administrators, Inc., with PacifiCare Health Systems, Inc. as the ultimate controlling parent.

PACIFICARE HEALTH SYSTEMS, INC.
ORGANIZATION CHART
(Effective August 1, 1997)



Territory and Plan of Operations

The Company has a certificate of authority to transact business as health maintenance organization in the state of Utah. It provides health care services to its members in Box Elder, Cache, Davis, Juab, Morgan, Salt Lake, San Pete, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties. Health Option is also authorized to transact business as a health maintenance organization in those counties. It provides lower cost, less rich benefit products as an alternative to the Company's products.

The Company advertises through various mediums, including newspapers, radio, television, and point of sale brochures and flyers. New and renewal business is solicited by in-house employee agents and outside independent agents. The Company does not use managing general agents as part of its agency force. The Company markets to groups of two or more eligible employees. An individual product was also available through Health Option during the examination period. However, individual contracts are no longer offered.

The combined member enrollment for the Company and Health Option as of the June 30, 1997 examination date comprised of the following:

Classification	Member Enrollees
Groups	170,883
Medicare Risk	11,593
Medicare Cost	1,781
Medicaid	18,110
Individual	3,877
Total	206,244

Company Growth

The tables below report the growth in membership and premium during the examination period for the Company and Health Option. Numbers were taken from their 1996 filed annual statements and June 30, 1997 quarterly statements.

PacifiCare of Utah, Inc.

As of Date	Member Enrollment	Premium & Related Revenue
June 30, 1997	206,244	$ 89,731,405
December 31,1996	194,731	$227,226,806
December 31, 1995	181,296	$237,123,031
December 31, 1994	174,562	$214,121,887

PacifiCare Health Option, Inc.

As of Date	Member Enrollment	Premium & Related Revenue
June 30, 1997	membership transferred to PacifiCare of Utah, Inc.	$1,240,343
December 31, 1996	"	$2,259,969
December 31,1995	"	$1,999,403
December 31, 1994	"	$5,754,184

PREVIOUS EXAMINATION FINDINGS

The previous market conduct examination report as of December 31, 1993, and financial examination reports as of December 31, 1994, performed by the Utah Insurance Department, were reviewed. The Company's written response to the findings and recommendations of the previous market conduct examination report was also reviewed. The response indicated corrective actions were taken by the Company with regard to the recommendations made in the previous report. However, during the current examination, the examiner noted similar discrepancies continued to occur with regard to each of the findings and corresponding recommendations addressed in the previous report. These discrepancies are identified in the Complaint Handling, Producer Relationships, Claims, and HMO Specific Requirements sections of the current report.

CURRENT EXAMINATION FINDINGS

Company Operations/Management

Certificates of Authority

The Certificates of Authority for the Company and for Health Option were reviewed and found to be current. The Company and Health Option are licensed for the line of business being written and are operating within the parameters of their Certificates of Authority.

Internal Audits

The Company did not have a formal internal audit function or audit reports during the examination period.

Anti-Fraud Plan

The Company does not have a formal written anti-fraud plan in place. However, fraud prevention policies and procedures have been incorporated into each respective department's policies and procedures. Pursuant to information provided by the Company, various anti-fraud measures have been implemented, such as: primary source verification of provider credentials, procedures to prevent duplication of paid claims, underwriting procedures to verify that a business applying for coverage has a definite employer/employee relationship, and an employee hotline for anonymous employee reports of perceived fraud.

Disaster Recovery Plan

During the examination period the Company maintained data on a mainframe computer system. All data recovery backups were made nightly and monthly and stored both on-site and off-site. The Company reported it had the diversity to spread operations to various off-site facilities in the event the current site were to become inoperable.

Computer Information/Data Security

The Company had a regional security coordinator in place during the examination period through whom all regional data security passed, including additions, deletions, and levels of security appropriate with job description. Security measures were implemented to log employees off of applications after approximately five minutes of non-use. Regional departments had data entry auditors for checking the original forms against the computer entries. Data was stored for statistical use in the Company's quality management facility warehouse.

Complaint Handling

A consolidated consumer complaints register was maintained by the Company for itself and Health Option of all complaints received directly from consumers. The Company also maintained a separate register of "Department of Insurance Complaints" received. However, none of the complaints received directly from consumers during 1994, nor those filed with the Utah Insurance Department against the Company during 1994 were listed in the Company's complaints registers. In addition, the Company failed to include two of the 1995 and two of the 1996 Utah Insurance Department complaints in the register.

There were a total of 46 consumer complaints filed with the Utah Insurance Department against the Company during the examination period, of which 18 were justified complaints. All forty-six complaints filed against the Company were requested for review. There were no complaints filed with the Utah Insurance Department specifically against Health Option during that same period. The following table shows a population breakdown of the complaints filed against the Company, by year, and the number of complaint files reviewed. The Company was unable to locate any of the 1994 files, two of the 1995 files, and one of the 1996 files. A copy of the missing 1996 complaint, as maintained by the Utah Insurance Department, was reviewed at the department. Three of the Company files reviewed were incomplete, with pertinent documentation missing from the files.

Complaints filed with the Utah Insurance Department

	1994	1995	1996	Through 6/30/97	Total
Justified	3	1	7	7	18
Other	9	2	10	7	28
Combined Total	**12**	**3**	**17**	**14**	**46**
Reviewed	0	1	17	14	32

Utah Insurance Department Rule R590-89, Unfair Claims Settlement Practices Rule, has a fifteen day maximum response time requirement for answering Utah Insurance Department inquiries respecting claims. Forty-three Utah Insurance Department inquiries were sent to the Company pertaining to the above thirty-two consumer complaints reviewed. Fourteen inquiries were not responded to by the Company until after fifteen days. At least nine of those inquiries were not responded to by the Company until after a follow up inquiry was sent to the Company. The Company was informed of the fifteen day response time requirement in it's prior market conduct examination report as of December 31, 1993, by the Utah Insurance Department. Failure to furnish the department with a substantive response within fifteen days is a violation of U.A.C. Subsection R590-89-10(B).

From January 1995 through June 1997 there were a total of eight hundred ninety-seven direct consumer complaints received by the Company and Health Option. The following table shows a population breakdown of those complaints, by year, the number of files requested for review, the number reviewed, and those unavailable for review for each of those years.

Consumer Direct Complaints

	1995	1996	Through 6/30/97	Total
Total Complaints	384	362	151	897
Requested for Review	8	10	13	31
Complaints Reviewed	5	10	13	28
Not Available for Review	3	0	0	3

The Company was unable to provide complaint population data or complaint files for the 1994 consumer direct complaints. Also, three of the 1995 files were unavailable for review. Failure to retain all grievance files for a period of not less than five years and to have them available for examination is a violation of U.A.C. Subsection R590-76-8(D).

Company procedures allowed seven to ten days to initially respond to a complaint received from a claimant during the examination period. U.A.C. R590-89 has a fifteen day maximum response time requirement for responding to pertinent communications from a claimant which reasonably suggest that a response is expected. In seven of the direct consumer complaint files reviewed, complaints received from claimants were not responded to by the Company until after ten days. In six of those cases, the complaints were not responded to until after fifteen days. Failure to respond to a claimant within fifteen days is a violation of U.A.C. R590-89-10(C).

Company procedures allowed fifty-eight days response time to answer a grievance received by the Company from an enrollee. However, U.A.C. R590-76, Health Maintenance Organizations, has a thirty day maximum response time requirement for answering in writing a grievance received from an enrollee. In twenty-one of the files reviewed, an answer was not sent by the Company until after thirty days. In three cases, there was no evidence in the file that the grievance was ever answered. In two cases, the answer was communicated verbally rather than in writing. A timeline was unable to be performed on one of the files reviewed, due to incomplete file documentation. Failure to answer a grievance in writing within thirty days of submittal is a violation of U.A.C. Subsection R590-76-8(C).

Marketing and Sales

Company products were marketed to prospective purchasers through in-house employee agents and outside independent agencies and agents. The Company advertised through various mediums, including newspapers, radio, television, billboards, direct mail, and point of sale brochures and flyers.

Company marketing and sales materials were reviewed, including the Company's annual sales and marketing business plans, written procedure guidelines, informational booklets, employer proposal packets and employee enrollment packets used by the Company's producers, advertisements, sales brochures and flyers, application and enrollment forms, policy benefit summaries, and other materials. Discrepancies noted as a result of this review are disclosed in the following two paragraphs.

Company and Health Option member handbook forms state, "Arbitration is generally recognized by the Utah Insurance Department as a more expedient, efficient alternative for resolving disputes than judicial remedies." Representing either directly or indirectly that the Utah Insurance Department has approved, reviewed, endorsed, or in any way favorable passed upon any practice or act is a violation of U.A.C. Section R590-154-5.

In one advertisement, the Company used a statistical reference without identifying the source of statistics used in the advertisement. Failure to identify the source of any statics used in an advertisement is a violation of U.A.C. Subsection R590-130-10(B).

Producer Relationships

The Company utilizes independent agencies and agents to market its products. It does not utilize managing general agencies, general agencies or third party administrators. The Company provided lists of the producers contracted and appointed by the Company and by Health Option. These lists were compared with Utah Insurance Department records of producers appointed with the Company and Health Option. In connection with this comparison, the examiners also reviewed producer contract language, producer contract files, effective dates of business produced, commissions paid to producers, and other information.

The Company's Producer Agreement requires the producer to indemnify and hold the Company harmless "from and against any and all claims, liabilities, demands, actions, causes of action, judgements, debts, damages and expenses..." arising from the action of the producer. This language in the Producer Agreement is in conflict with U.C.A. Subsection 31A-23-311, which requires the insurer to be liable to the insured for losses if the premium was received by an agent who placed the insurance. It is also in conflict with U.C.A. Subsection 31A-23-305, which requires every insurer to be bound by any act of its agent performed within the scope of the agent's actual (express or implied) or apparent authority. According to U.C.A. Subsection 31A-23-219, there is a rebuttable presumption that in placing a risk with the insurer the appointed licensee acted as the insurer's agent.

The Company's Producer Agreement states, "If the Producer receives funds for the account of Company, these funds shall not be deposited by the Producer into any bank account, but shall be remitted to Company within five (5) business days after such funds are received by the Producer." This language in the Producer Agreement is in conflict with U.C.A. Subsection 31A-23-310, which requires such funds to be deposited into a federally insured trust account, or other account approved by the commissioner, unless the funds are sent to the appropriate payee by the close of the next business day after their receipt.

The language of some Company Producer Agreements states, "Producer may sell only those products specifically authorized and designated on Exhibit 2 hereto. Producer is not authorized to solicit any other products...". However, the exhibits reviewed in the producer files containing those agreements were generally left blank, with no products designated.

Company policy is to maintain a current copy of the producers license in the file. The producer agreement requires producers to furnish the Company with a copy of the license upon executing the agreement and an updated copy upon each license renewal. Ten files did not have a current copy of the license in the file. Two of the producer files requested for review were unable to be located.

A Certificate of Appointment was not on file with the Utah Insurance Department for one agent who was included on Health Option's list of appointed agents. In five cases, agents were contracted with the Company or Health Option, although the agents were not included on the applicable Company or Health Option list of appointed agents, and a Certificate of Appointment was not on file with the Utah Insurance Department. In at least ten cases, agents produced business for the Company or Health Option while no appointment was in place. The Company was informed of the requirement to appoint an agent prior to the agent doing business for the Company in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department. Failure to appoint an agent prior to the agent doing business for the Company is a violation of U.C.A 31A-23-219(1). Failure to file a Certificate of Appointment with the Utah Insurance Department is a violation of U.A.C. Subsection R590-101-4.

Two of the agents who produced business while no appointment was in place were not licensed in Utah to sell insurance. In both cases, the agents were compensated for the business produced. The Company was informed in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department of the requirement to ensure a person is properly licensed prior to utilizing the person's services as an agent and prior to compensating the person for services performed as an agent. Utilizing the services of another as an agent when the Company knows or should know the other does not have a license as required by law is a violation of U.C.A. 31A-23-201. Compensating a person for services performed as an agent, when the Company knows or should know the payee is not properly licensed, is a violation of U.C.A. 31A-23-404(1).

Seventeen agents were appointed with the Company or Health Option, although there was no evidence in the producer files of an applicable agency contract. At least three of those agents were paid commissions for business produced. The Company was informed in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department of the requirement to have a written agency contract in place with an agent prior to the agent doing business for the Company. Representing a Company without an appointment and a written agency contract is a violation of U.C.A. Subsection 31A-23-309.

Underwriting/Rating

General

Health insurance benefits were provided by the Company and Health Option to small employer groups as well as large employer groups, and their dependents. Benefits were also provided to Medicare eligible individuals, and to individuals converting from a group plan.

Small groups were underwritten upon application and either accepted or rejected, or in cases of 15 or more eligible employees, possibly rate adjusted. Individual subscribers and their dependents within small groups of up to 24 eligible employees were medically underwritten on an individual basis. Subscribers in groups of 25 or more were generally not medically underwritten on an individual basis. During the examination period, Health Option also underwrote individual policies through its "Independent Plan," until April 1997, when it discontinued offering this plan. Individual applicants were underwritten upon application and either accepted or rejected.

The Company and Health Option limited their liability during the examination period through the use of policy limitations and exclusions, co-payments for services rendered, exclusive use of authorized providers for non-emergency care, pre-authorization of certain specialized medical procedures, and with certain plans, pre-existing condition clauses.

Rating factors used by the Company and Health Option in the development of their rates included benefit design, age, family composition, geographic area, industry and claims experience. Rates, rating manuals, and rating procedures and practices were reviewed. No material discrepancies were noted.

Review of Forms and Required Filings

Policy forms and other required filings were reviewed. A policies and procedures manual covering this area was also requested for review. The Company does not have written procedural guidelines specifically addressing forms and required filings.

None of the enrollment or application forms used by the Company and Health Option have been filed with the Utah Insurance Department. Failure to file a form prior to its use is a violation of U.C.A. Subsection 31A-21-201(1), and U.A.C. Subsection R590-86-3(A).

The application form used by the Company in marketing its "Independent Plan" to individuals during the examination period did not include a question to elicit information as to whether the insurance to be issued was intended to replace any other disability policy or certificate in force. Failure to include such a question in the application form is a violation of U.A.C. Subsection R590-126-9.A.

According to the language of the Company's and Health Option's "Conversion Plan" member handbooks, application for conversion benefits must be made "within 30 days of termination or loss of eligibility under a group plan." According to their benefit brochures, payment of the "initial premium is due within 30 days of termination from the group plan." However, U.C.A. Subsection 31A-22-704(1) allows 60 days after termination of coverage for application and payment.

The preexisting condition definition language used in some Company and Health Option member handbooks and benefit brochures defines a preexisting condition more restrictively than allowed under U.C.A. Subsection 31A-30-107(4).

Health Option's "Conversion Plan" benefit brochure was issued under the Company's name rather than under Health Option's name. Failure to disclose the name of the actual insurer is a violation of U.A.C. R590-130-12.A.

Underwriting File Review

Underwriting files for group policies issued or terminated by the Company between January 1, 1994 and December 31, 1996 were reviewed. Individual policies issued during that same period were also reviewed. The sample selected and reviewed in each of these categories are shown in the table on the following page.

Underwriting File Sample

Category	Sample Selected	Reviewed
Issued Groups	51	51
Terminated Groups	21	12
Individual Policies	15	15
Combined Total	87	78

Forty-two of the issued groups files reviewed involved small employer groups. In thirty-nine of those small employer group files, the Company failed to retain a signed statement from the employer that the Company offered to accept all eligible employees and their dependents at the same level of benefits under the health benefit plan provided to the employer. Failure to retain a statement to that effect is a violation of U.A.C. Subsection R590-176-5.A.1.

Nineteen issued group files reviewed had other missing documentation and could not be thoroughly reviewed. Nine terminated group files requested for review could not be located by the Company. The only information found pertaining to the fifteen individual policy files requested for review was the new business application form, including an attached health questionnaire. In ten of those cases, the health questionnaire was missing from the file. In two individual policy files and one issued group file, the application forms were not signed by the agent.

Policyholder Service

Seventy-two group and fifteen individual policyholder files were requested for review. Nine group files requested could not be located by the Company, and no policyholder service records could be found pertaining to the fifteen individual policy files requested. The remaining sixty-three group policyholder files were reviewed with regard to policyholder service and treatment, including a review of notices, billings, delays, timely response, premium administration and refunds, coverages, endorsements, cancellations and reinstatements. No discrepancies related to policyholder service were encountered as a result of this review.

Claims

General

The Company processes commercial claims from contracted and non-contracted providers for its own members and for Health Option members. It also processes medicare and medicaid claims. Claims processed by the Company include both paper claims and electronically submitted claims. Pre-paid capitated provider claims are processed the same as non-capitated claims for utilization data purposes. However, encounter data received from the Talbert centers is electronically submitted and is not included as a part of the utilization data.

The following chart reflects the dollar amount of claims paid by the Company for itself and Health Option during the examination period.

Paid Claims in Dollars

1996	209,440,013
1995	213,153,778
1994	189,435,570
1993	152,010,060
(The figures shown were taken from the Company's December 31, 1996 filed annual statement, page 30.)	

Claims Review

The Company processed 1,848,626 commercial claims during the examination period. Of those, 398,936 were processed during 1994; 474,711 during 1995; 574, 351 during 1996; and 400,628 through June 30, 1997. A timeline compliance review was performed on the entire database of the commercial claims processed during the examination period. A more detailed claim file analysis was also performed on a sample of 76 claims selected from that database to determine compliance with Utah statutes and rules, as well as with the Company's own policies and procedures. The sample selected for the more detailed review consisted of 10 claim files from 1994, 15 from 1995, 26 from 1996, and 25 from 1997.

U.A.C. Subsection Section R590-89-10(A), requires acknowledgment of claims not settled within fifteen days of receiving notification of the claim. Seventy-eight (78) percent of the claims processed by the Company during the examination period did not meet this requirement. It was recommended in the previous market conduct examination report as of December 31, 1993, that the Company review its procedures for notifying claimants of receipt of their claims so as to ensure compliance with this requirement. However, neither the Company nor Health Option have procedures in place to ensure compliance with this requirement.

The Company has a goal to settle claims within thirty days of receipt of the claim. This conforms with the Utah Insurance Department's guideline of settlement within thirty days of receipt of the claim. Forty-six (46) percent of the claims processed by the Company during the examination period did not meet this goal. Nineteen (19) percent of the claims processed by the Company during the examination period were not settled until after forty-five days of receipt of the claim. The average number of calendar days from receipt of the claim until settlement of the claim during the examination period was thirty-three (33) days.

In those cases reviewed where the investigation and settlement of the claim exceeded thirty days, the Company generally failed to communicate with the claimant at least every thirty days as to the status of the claim. The Company did not have procedures in place to ensure such communication with the claimant. Failure to communicate with the claimant at least every thirty days as to the status of the claim until the claim is either paid or denied is a violation of U.A.C. Subsection R590-89-12(B).

In those cases reviewed where the investigation and settlement of the claim exceeded forty-five days after notification of the claim, the examiner was unable to determine from the records provided whether the investigation could have reasonably been completed within forty-five days. Failure to either complete the investigation within forty-five days after notification of the claim, or establish through adequate records that the investigation could not be completed within forty-five days of notification is a violation of U.A.C. Subsection R590-89-11. Failure to adequately document the claim file is a violation of U.A.C. Subsection R590-89-8.

HMO Specific Requirements

In addition to the general regulatory requirements for insurers, health maintenance organizations have other specific regulatory requirements to comply with. The additional market conduct requirements are found in U.C.A. Chapter 31A-8, Health Maintenance Organizations and Limited Health Plans, and in U.A.C. Rule R590-76, Health Maintenance Organizations.

Company operations were reviewed with regard to these additional specific regulatory requirements, including a review of provider relations materials, provider contract language, provider credentialing, provider malpractice insurance requirements, provider quality control procedures and provider complaint procedures.

U.C.A. Subsection 31A-8-404 requires each health maintenance organization to prepare certified annual reports of the effectiveness of the organization's internal quality control. The examiner found no evidence of compliance with this requirement by Health Option. Company management stated to the examiner that the annual reports prepared by the Company as to the effectiveness of its internal quality control were also applicable to the internal quality control of Health Option. However, there was no express reference to Health Option in the annual reports examined.

U.A.C. Subsection R590-76-10 requires each health maintenance organization to develop a quality assurance plan, to arrange and pay for a review and certification of its plan, and to show written evidence of continuing internal peer reviews of medical care given. The examiner found no evidence of compliance with these requirements by Health Option. Company management stated to the examiner that the Company's quality assurance plan, review and certification of its plan, and internal peer review reports of its medical care given were also applicable Health Option. However, there was no express reference to Health Option in the quality assurance plan or in any of the written reviews examined.

Provider File Review

Provider lists were supplied by the Company from which contracting and credentialing information pertaining to sixty-seven contracted health service providers was reviewed, including hospitals, physicians, pharmacies, and other practitioners. The Company did not maintain evidence of current licensing documentation, or of current professional liability insurance documentation for any of the facility providers or pharmacy providers reviewed. The Company was informed of the requirement to maintain evidence of professional liability insurance in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department. Failure to maintain evidence of current professional liability insurance is a violation of U.A.C. Subsection R590-76-12.F.

SUMMARIZATION

Summary

Comments included in this report which are considered to be significant and requiring special attention are summarized below:

1. Utah Insurance Department Rule R590-89, Unfair Claims Settlement Practices Rule, has a fifteen day maximum response time requirement for answering Utah Insurance Department inquiries respecting claims. Forty-three Utah Insurance Department inquiries were sent to the Company pertaining to the thirty-two consumer complaints reviewed. Fourteen inquiries were not responded to by the Company until after fifteen days. At least nine of those inquiries were not responded to by the Company until after a follow up inquiry was sent to the Company. The Company was informed of the fifteen day response time requirement in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department. Failure to furnish the department with a substantive response within fifteen days is a violation of U.A.C. Subsection R590-89-10(B). The examiner recommends procedures be implemented or changed to ensure all Utah Insurance Department inquiries are responded to by the Company within the 15 day maximum response time requirement. **(COMPLAINT HANDLING)**

2. Company procedures allowed seven to ten days to initially respond to a complaint received from a claimant during the examination period. U.A.C. R590-89 has a fifteen day maximum response time requirement for responding to pertinent communications from a claimant which reasonably suggest that a response is expected. In seven of the direct consumer complaint files reviewed, complaints received from claimants were not responded to by the Company until after ten days. In six of those cases, the complaints were not responded to until after fifteen days. Failure to respond to a claimant within fifteen days is a violation of U.A.C. R590-89-10(C). The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this response time requirement to communication received from a complainant and with the Company's own procedural requirements. **(COMPLAINT HANDLING)**

3. Company procedures allowed fifty-eight days response time to answer a grievance received by the Company from an enrollee. However, U.A.C. R590-76, Health Maintenance Organizations, has a thirty day maximum response time requirement for answering in writing a grievance received from an enrollee. In twenty-one of the consumer direct files reviewed, an answer was not sent by the Company until after thirty days. In three cases, there was no evidence in the file that the grievance was ever answered. In two cases, the answer was communicated verbally rather than in writing. Failure to answer a grievance in writing within thirty days of submittal is a violation of U.A.C. Subsection R590-76-8(C). The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this response time requirement for answering a grievance and with the Company's own procedural requirements. **(COMPLAINT HANDLING)**

4. The Company was unable to locate any of the 1994 Utah Insurance Department complaint files, two of the 1995 files, and one of the 1996 files. In addition, the Company was unable to provide complaint population data or complaint files for the 1994 consumer direct complaints. Failure to retain all grievance files for a period of not less than five years and to have them available for examination is a violation of U.A.C. Subsection R590-76-8(D). The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this record retention requirement. **(COMPLAINT HANDLING)**

5. None of the complaints received directly from consumers during 1994, nor those filed with the Utah Insurance Department against the Company during 1994 were listed in the Company's complaints registers. In addition, the Company failed to include two of the 1995 and two of the 1996 Utah Insurance Department complaints in the register. The examiner recommends the Company maintain all complaints in its complaint register. **(COMPLAINT HANDLING)**

6. Three of the files reviewed of complaints filed with the Utah Insurance Department against the Company were incomplete, with pertinent documentation missing from the files. Pertinent documentation was also missing from one of the consumer direct complaint files reviewed. The examiner recommends the Company review and/or implement quality control procedures to ensure all complaint files be adequately documented by the Company. **(COMPLAINT HANDLING)**

7. Company and Health Option member handbook forms state, "Arbitration is generally recognized by the Utah Insurance Department as a more expedient, efficient alternative for resolving disputes than judicial remedies." Representing either directly or indirectly that the Utah Insurance Department has approved, reviewed, endorsed, or in any way favorable passed upon any practice or act is a violation of U.A.C. Subsection R590-154-5. The examiner recommends the Company change the member handbook forms to comply with this rule. **(MARKETING AND SALES)**

8. In one advertisement, the Company used a statistical reference without identifying the source of statistics used in the advertisement. Failure to identify the source of any statistics used in an advertisement is a violation of U.A.C. Subsection R590-130-10(B). The examiner recommends the Company correct the advertisement to comply with this rule. **(MARKETING AND SALES)**

9. The Company's Producer Agreement requires the producer to indemnify and hold the Company harmless "from and against any and all claims, liabilities, demands, actions, causes of action, judgements, debts, damages and expenses..." arising from the action of the producer. This language in the Producer Agreement is in conflict with U.C.A. Subsection 31A-23-311, which requires the insurer to be liable to the insured for losses if the premium was received by an agent who placed the insurance. It is also in conflict with U.C.A. Subsection 31A-23-305, which requires every insurer to be bound by any act of its agent performed within the scope of the agent's actual (express or implied) or apparent authority. According to U.C.A. Subsection 31A-23-219, there is a rebuttable presumption that in placing a risk with the insurer the appointed licensee acted as the insurer's agent. The examiner recommends the Company change the language in its Producer Agreement to conform with these statutes. **(PRODUCER RELATIONSHIPS)**

10. The Company's Producer Agreement states, "If the Producer receives funds for the account of Company, these funds shall not be deposited by the Producer into any bank account, but shall be remitted to Company within five (5) business days after such funds are received by the Producer." This language in the Producer Agreement is in conflict with U.C.A. Subsection 31A-23-310, which requires such funds to be deposited into a federally insured trust account, or other account approved by the commissioner, unless the funds are sent to the appropriate payee by the close of the next business day after their receipt. The examiner recommends the Company change the language in its Producer Agreement to conform with these fiduciary requirements. **(PRODUCER RELATIONSHIPS)**

11. The language of some Company Producer Agreements states, "Producer may sell only those products specifically authorized and designated on Exhibit 2 hereto. Producer is not authorized to solicit any other products...". However, the exhibits reviewed in the producer files containing those agreements were generally left blank, with no products designated. The examiner recommends the Company review and/or implement quality control procedures to ensure such referenced exhibits Producer Agreements be adequately completed. **(PRODUCER RELATIONSHIPS)**

12. Company policy is to maintain a current copy of the producers license in the file. The producer agreement requires producers to furnish the Company with a copy of the license upon executing the agreement and an updated copy upon each license renewal. Ten files did not have a current copy of the license in the file. The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with the Company's own policy concerning maintenance of producer licensing records. **(PRODUCER RELATIONSHIPS)**

13. A Certificate of Appointment was not on file with the Utah Insurance Department for one agent who was included on Health Option's list of appointed agents. In five cases, agents were contracted with the Company or Health Option, although the agents were not included on the applicable Company or Health Option list of appointed agents, and a Certificate of Appointment was not on file with the Utah Insurance Department. In at least ten cases, agents produced business for the Company or Health Option while no appointment was in place. The Company was informed of the requirement to appoint an agent prior to the agent doing business for the Company in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department. Failure to appoint an agent prior to the agent doing business for the Company is a violation of U.C.A 31A-23-219(1). Failure to file a Certificate of Appointment with the Utah Insurance Department is a violation of U.A.C. Subsection R590-101-4. The examiner recommends procedures be implemented or changed to ensure, in all cases, producers are appointed prior to doing business for the Company or Health Option and the Certificate of Appointment is filed with the Utah Insurance Department. **(PRODUCER RELATIONSHIPS)**

14. Two of the agents who produced business while no appointment was in place were not licensed in Utah to sell insurance. In both cases, the agents were compensated for the business produced. The Company was informed in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department of the requirement to ensure a person is properly licensed prior to utilizing the person's services as an agent and prior to compensating the person for services performed as an agent. Utilizing the services of another as an agent when the Company knows or should know the other does not have a license as required by law is a violation of U.C.A. 31A-23-201. Compensating a person for services performed as an agent, when the Company knows or should know the payee is not properly licensed, is a violation of U.C.A. 31A-23-404(1). The examiner recommends procedures be implemented or changed to ensure, in all cases, producers are properly licensed prior to doing business for the Company and prior to being compensated by the Company. **(PRODUCER RELATIONSHIPS)**

15. Seventeen agents were appointed with the Company or Health Option, although there was no evidence in the producer files of an applicable agency contract. At least three of those agents were compensated for business produced by them. The Company was informed in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department of the requirement to have a written agency contract in place with an agent prior to the agent doing business for the Company. Representing a Company without a written agency contract is a violation of U.C.A. Subsection 31A-23-309. The examiner recommends procedures be implemented or changed to ensure, in all cases, producers have a written agency contract in effect prior to doing business for the Company or Health Option. **(PRODUCER RELATIONSHIPS)**

16. None of the enrollment or application forms used by the Company and Health Option were filed with the Utah Insurance Department. Failure to file a form prior to its use is a violation of U.C.A. Subsection 31A-21-201(1), and U.A.C. Subsection R590-86-3(A). The examiner recommends the Company review and/or implement quality control procedures to ensure all forms are filed in accordance with statutory and regulatory requirements prior to their use. **(UNDERWRITING/RATING)**

17. The application form used by the Company in marketing its "Independent Plan" to individuals during the examination period did not include a question to elicit information as to whether the insurance to be issued was intended to replace any other disability policy or certificate in force. Failure to include such a question in the application form is a violation of U.A.C. Subsection R590-126-9.A. The Company is currently not marketing policies to individuals in Utah. The examiner recommends the Company comply with this statute in any policies marketed to individuals in Utah in the future. **(UNDERWRITING/RATING)**

18. According to the language of the Company's and Health Option's "Conversion Plan" member handbooks, application for conversion benefits must be made "within 30 days of termination or loss of eligibility under a group plan." According to their benefit brochures, payment of the "initial premium is due within 30 days of termination from the group plan." However, U.C.A. Subsection 31A-22-704(1) allows 60 days after termination of coverage for application and payment. The examiner recommends the language in the member handbooks and benefit brochures be amended to allow at least 60 days for application and payment after termination of coverage. **UNDERWRITING/RATING)**

19. The preexisting condition definition language used in some Company and Health Option member handbooks and benefit brochures defines a preexisting condition more restrictively than allowed under U.C.A. Subsection 31A-30-107(4). The examiner recommends the preexisting condition definition of the policy form be amended to comply with this statute. **(UNDERWRITING/RATING)**

20. Health Option's "Conversion Plan" benefit brochure was issued under the Company's name rather than under Health Option's name. Failure to disclose the name of the actual insurer is a violation of U.A.C. R590-130-12.A. The examiner recommends the benefit brochure be changed to disclose the name of the actual insurer. **(UNDERWRITING/RATING)**

21. At least nineteen issued group files reviewed had missing documentation and could not be thoroughly reviewed. All fifteen of the individual policy files reviewed also had missing or incomplete documentation. The examiner recommends the Company review and/or implement quality control procedures to ensure all underwriting files be adequately documented by the Company. **(UNDERWRITING/RATING)**

22. In thirty-nine small employer group files reviewed, the Company failed to retain a signed statement from the employer that the Company offered to accept all eligible employees and their dependents at the same level of benefits under the health benefit plan provided to the employer. Failure to retain a statement to that effect is a violation of U.A.C. Subsection R590-176-5.A.1. The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this rule. **(UNDERWRITING/RATING)**

23. Nine terminated group files requested for review could not be located by the Company. The examiner recommends the Company review and/or implement quality control procedures to enable the Company to provide regulatory examiners with requested files in a timely manner in future examinations. **(UNDERWRITING/RATING)**

24. Policy forms and other required filings were reviewed. A policies and procedures manual covering this area was also requested for review. The Company does not have written procedural guidelines specifically addressing forms and required filings. The examiner recommends the Company prepare written policy and procedure guidelines specifically addressing policy forms and required filings. **(UNDERWRITING/RATING)**

25. U.A.C. Subsection Section R590-89-10(A), requires acknowledgment of claims not settled within fifteen days of receiving notification of the claim. Seventy-eight (78) percent of the claims processed by the Company during the examination period did not meet this requirement. It was recommended in the previous market conduct examination report as of December 31, 1993, that the Company review its procedures for notifying claimants of receipt of their claims so as to ensure compliance with this requirement. However, as of the current examination, the Company did not have procedures in place to ensure compliance with this requirement. The examiner recommends the Company prepare written policy and procedure guidelines specifically addressing policy forms and required filings. **(CLAIMS)**

26. The Company has a goal to settle claims within thirty days of receipt of the claim. This conforms with the Utah Insurance Department's guideline of settlement within thirty days of receipt of the claim. However, forty-six (46) percent of the claims processed by the Company during the examination period did not meet this goal. The average number of calendar days from receipt of the claim until settlement of the claim during the examination period was thirty-three (33) days. The examiner recommends the Company review and/or implement quality control procedures to better meet its own timeline goals and Utah Insurance Department guidelines. **(CLAIMS)**

27. In those cases reviewed where the investigation and settlement of the claim exceeded thirty days of receipt of the claim, the Company generally failed to communicate with the claimant at least every thirty days as to the status of the claim. The Company did not have procedures in place to ensure such communication with the claimant. Failure to communicate with the claimant at least every thirty days as to the status of the claim until the claim is either paid or denied is a violation of U.A.C. Subsection R590-89-12(B). The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this requirement. **(CLAIMS)**

28. Nineteen (19) percent of the claims processed by the Company during the examination period were not settled until after forty-five days of receipt of the claim. In those cases reviewed where the investigation and settlement of the claim exceeded forty-five days after notification of the claim, the examiner was unable to determine from the records provided whether the investigation could have reasonably been completed within forty-five days. Failure to either complete the investigation within forty-five days after notification of the claim, or establish through adequate records that the investigation could not be completed within forty-five days of notification is a violation of U.A.C. Subsection R590-89-11. Failure to adequately document the claim file is a violation of U.A.C. Subsection R590-89-8. The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with these requirements.**(CLAIMS)**

29. U.C.A. Subsection 31A-8-404 requires each health maintenance organization to prepare certified annual reports of the effectiveness of the organization's internal quality control. The examiner found no evidence of compliance with this requirement by Health Option. Company management stated to the examiner that the annual reports prepared by the Company as to the effectiveness of its internal quality control were also applicable to the internal quality control of Health Option. However, there was no express reference to Health Option in the annual reports examined. The examiner recommends the required reports be prepared expressly referencing Health Option in the reports. **(HMO SPECIFIC REQUIREMENTS)**

30. U.A.C. Subsection R590-76-10 requires each health maintenance organization to develop a quality assurance plan, to arrange and pay for a review and certification of its plan, and to show written evidence of continuing internal peer reviews of medical care given. The examiner found no evidence of compliance with these requirements by Health Option. Company management stated to the examiner that the Company's quality assurance plan, review and certification of its plan, and internal peer review reports of its medical care given were also applicable Health Option. However, there was no express reference to Health Option in the quality assurance plan or in any of the written reviews examined. The examiner recommends the required quality assurance plan, review and certification of the plan, and written evidence of continuing internal peer reviews of medical care given be developed with express reference to Health Option. **(HMO SPECIFIC REQUIREMENTS)**

31. The Company and Health Option did not maintain evidence of current licensing documentation, or of current professional liability insurance documentation for any of the facility providers or pharmacy providers reviewed. The Company was informed of the requirement to maintain evidence of professional liability insurance in it's previous market conduct examination report as of December 31, 1993, by the Utah Insurance Department. Failure to maintain evidence of current professional liability insurance is a violation of U.A.C. Subsection R590-76-12.F. The examiner recommends the Company and Health Option comply with these reporting requirements, using a format the Company and Health Option deem best in lieu of a format prescribed by the Commissioner. **(HMO SPECIFIC REQUIREMENTS)**

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

In addition to the undersigned, Brian W. Hansen, FLMI, CFE, Market Conduct Examiner, assisted in the examination.

Randal A. Overstreet, MBA, AIE
Market Conduct Examiner
Examiner-in-Charge
Utah Insurance Department